4.9 When is the Resident Assessment Instrument Not Enough?

Federal requirements support a facility's ongoing responsibility to assess a resident. The Quality of Care regulation[2] requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Services provided or arranged by the facility must also meet professional standards of quality. Compliance with these regulations requires that the facility monitor the resident's condition and respond with appropriate care planning interventions.

The MDS is a screening instrument and does not include detailed descriptions of all factors necessary for care planning and evaluation. When completing the MDS, the assessor simply indicates whether or not a factor is present. For certain clinical situations, if the MDS indicates the presence of a potential resident problem, need, or strength, the assessor may need to investigate and document the resident's condition in more detail. For example, if a resident is noted as having a contracture on the MDS, additional documentation in the record may include the number of contractures present, sites, and degree of restriction in each affected joint. RAPs also assist in gathering additional information for some clinical conditions.

In addition, completion of the MDS/RAPs does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether or not the appropriate areas are included in the RAI. For example, the MDS includes a listing of those diagnoses that affect the resident's functioning or needs in the past 7 days. While the MDS may indicate the presence of medical problems, such as unstable diabetes or orthostatic hypotension, there should be evidence of additional assessment of these factors if relevant to the development of the care plan for an individual resident. The need for a physical examination detailing findings in pertinent body sub-systems is another example.

Some facilities have reacted to the Federal requirements for resident assessment by creating lengthy and cumbersome assessment tools, which are completed for each resident in addition to the State RAI. This is not a Federal requirement and often not a desirable use of facility staff resources. Additional assessment is necessary only for factors that are relevant for an individual resident. For example, an extensive cognitive status assessment is not necessary if no deficits were noted using the MDS. Likewise, using multiple assessment tools that basically measure the same thing is often a poor use of clinical resources. All members of the interdisciplinary team should be trained in assessment and capable of determining what is necessary and appropriate for a particular resident. Elaborate assessment systems should not necessarily replace the judgment of the team members.

4.10 Case Example - MDS, RAP and Care Planning

This case example is structured from the point of view of the nurse responsible for coordinating the RAI and care planning processes. It is organized in a series of stages, corresponding to how the care team acquired and used information in the MDS and RAPs.

[2] 42 CFR 483.25--(F 309)

In this case example:

- The processes of completing the MDS/RAP assessment [RAI] and developing an individualized care plan are illustrated.
- The goal is to show how MDS assessment information leads you to further assessment (by reviewing triggered RAPs) and to care planning.
- The RAP Summary forms are shown as part of this example to illustrate how this specific form can aid in coordinating and facilitating the flow of assessment data and decision-making.

This example does NOT:

- Represent a functionally complete MDS, RAP review and care planning process. Certain assessment areas and elements of care, although very appropriate, are not presented as part of this example.

1. THE ASSESSMENT PROCESS

We begin the MDS assessment process with examples of notes from the clinical record and conversations between caregivers displaying assessment points over the first few days of residency. These examples illustrate that MDS and RAP assessment information is being gathered from the point of admission, although the MDS form itself may be completed later.

Day 1 (Initial Admission of Mr. S from the hospital)

Following his admission, the following SOAP note was written on admission.

S: "Come sit with me, Joanne. I am so thirsty. Get me some water," says Mr. S talking to wife Marion. (Joanne is his sister who expired 12 years ago.) Wife stated that he never refers to her as his sister, but that since he was admitted to the hospital he has been more confused.

O: Mr. S admitted from the hospital, s/p left hip replacement. Mr. S has a five-year history of Alzheimer's disease, and has been attending the Cognitive Impairment Clinic at the hospital for three years.

According to hospital discharge summary, Mr. S was agitated in the ER, and was given Haldol IM several times during his stay in the hospital. His dehydration was treated successfully with IV fluids. He was "very confused, more so than what the wife previously indicated." Other new medications include ranitidine (Zantac), Morphine, Bactrim DS for a diagnosed urinary tract infection. He remained restrained throughout his stay.

Mr. S is oriented only to self and responds to his name only. He refers to his wife as his sister (new for him). He is not aware that he is in a nursing facility, or that he was in a hospital. He continuously picks at his bedclothes, and fidgets with the call light.

A: Acute confusion possibly related to hospitalization, medications, urinary tract infection, pain and isolation.

P: Monitor closely for safety. Do not use restraints. Begin 15 minute checks while awake. Encourage out of room activities. Resident continuing on Bactrim DS for six more days. Consult with physician about medication regimen. Ask daughter to bring in some of Mr. S.'s favorite articles to reorient him. Encourage frequent visits from family, explaining to them about Mr. S's change in cognitive status. Monitor closely for hip pain. Medicate with Tylenol for discomfort. Maintain pain flow sheet in the clinical record to assess effectiveness of pain regimen.

Day 2 (Note by physician on her visit with Mr. S)

I saw Mr. S today in the home where he was newly admitted. He has a five-year history of Alzheimer's disease, complicated by an acute confusional state. His hospitalization for hip repair was complicated by a urinary tract infection, dehydration, and acute confusional state. Whether the dehydration, infection, or medications was the cause of the cognitive changes is uncertain at this time. Wife reports that he was having difficulty urinating prior to admission, but thought that it was normal, considering his history of an enlarged prostate. I discontinued morphine and started Tylenol, 650 mg every six hours, since admission. Also, I changed his Haldol to p.o. and will slowly decrease the dosage. Continue with Bactrim DS until course completed. Discontinue Zantac. It is unclear why he was started on it and it may be contributing to his confusion. Monitor Intake and Output for next 7 days. I will do a further exam of Mr. S on Monday.

Day 4 (The following is an example of a dialogue between the nurse and the social worker about what was learned in admission examinations. It does not represent documentation, but serves to illustrate the interdisciplinary assessment processes. Also included on this day are the follow-up nursing notes and a separate physical therapy note. Staff's awareness of the needs and treatments for the resident is expanding.)

SOCIAL WORKER (SW):

"I spoke with Mr. S, his wife Marion and oldest daughter, Susan, the first two days of admission. Throughout the conversation, Mr. S was unable to answer simple questions. He was easily sidetracked and would become consumed with smoothing out his bedclothes. Marion and Susan said that normally he can't answer simple questions about his immediate needs, but he can talk endlessly about woodworking and opera."

***NURSE (N)*:**

"Mr. S is much clearer today. Although he didn't remember meeting me before, he responded to his name, and stated that he was not in his home, but in an old person's home. His wife was present and he called her by her proper name."

SW: "Mary (the nurse on evenings) told me that his cognition would probably continue to improve once his delirium clears. I have shared this with the family who seemed relieved."

N: "She is probably right. The UTI, dehydration, morphine, Zantac and Haldol probably contributed to his acute confusion, but because he has Alzheimer's disease, it makes it difficult to assess his baseline."

SW: "Well, his family described a gregarious man, who enjoyed attending the Alzheimer's Day Care Program at the community center. He was diagnosed with Alzheimer's disease five years ago, although the daughter stated she felt that he was having problems several years before the actual diagnosis. Also, Mr. S's wife told me that he was having increasing difficulties with his ADLs. She would have to break tasks down into sub-tasks. He required lots of cueing for dressing especially."

N: "He had his admission physical exam yesterday. Under the circumstances, everything seems O.K. His enlarged prostate probably causes some urinary retention, which would have put him at greater risk for the urinary tract infection, but his surgical incision line was clean. He appears well hydrated, and the nurse assistants from the day and evening shift indicate that he is taking in ample fluids. He continues to manipulate bedclothes, which according to his wife is a new activity, but it is tapering off. This could represent a resolution of his acute confusion. We will continue to monitor his intake and output, and cognition in light of his acute confusion. He is at risk for falling. He still has a few more days on his antibiotic for his UTI. The physical therapist will be seeing him today in fact. I'm going to write a brief note to document the areas we covered in these conversations."

NURSING NOTE

Discussed Mr. S's condition with Social Worker. Mr. S seems to be "clearer today." He is oriented to person, able to identify his wife by her correct name, and is aware that he is not in his home. He identifies his property that his wife brought in from home (picture and opera posters), and his fidgeting with the bedclothes has lessened. As his acute confusion improves we should see a returning to baseline. On exam Mr. S. appeared well hydrated, I/O adequate according to reports from nurse assistants. He appears in mild discomfort only when he ambulates, and is receiving Tylenol regularly. His dose of Haldol is being slowly tapered. He does not appear to have any negative effects from this.

K. Phillips, R.N.

PHYSICAL THERAPY NOTE

Mr. S sustained a fall and fractured his left hip. He underwent a successful replacement of the hip, and was cleared for light weight-bearing status. Because of his worsening cognition, and additional problems, he has not been ambulating except out of bed to the commode with nursing staff.

According to the daughter, who was involved with his care at home, his fall was an isolated event. Usually he ambulates around his home, Adult Day Care, and takes frequent walks without event. Orthostatic blood pressures and pulses from the end of his hospitalization and since admission here have been within normal limits, with orthostatic changes noted upon admission to the hospital.

His fall at home occurred at 2 am. The resident was very restless the entire day. He appeared to be having difficulty urinating. His wife was planning to take him into the doctor's office in the morning. Mr. S. got out of bed and was found wandering around the house. His wife tried to get him to return to bed, but he went into the bathroom, got into the shower - with his clothing on - and fell. Wife is not certain if he slipped or just fell.

Upon examination, he did not have orthostatic changes in his blood pressure or heart rate from a lying to upright position. He was able to get out of bed to a standing position with contact guard. Using his new walker, he was able to move to the hallways - safely. He did seem confused about the walker, but followed my commands appropriately.

This resident is ready to bear full weight. Staff should walk with him three times a day using contact guard and cueing for the walker. A sign that reads, "Mr. S remember your pusher" (his word for walker) was placed by his bed and by the inside of the door. According to notes from the Cognitive Impairment Clinic, he is able to read and follow simple written directions.

Assessment: Mr. S is at risk for future falls due to his recent fracture and hip replacement, cognitive impairments, new required use of walker (which he may get to a point that he doesn't need), and residual acute confusion. Plan: Monitor closely; contact guarding with all ambulation. Ambulate in hallway at least three times a day. Slowly increase distance, over the next two weeks, from room to dining room.

J. Smith, P.T.

Day 5 (Example of documentation of additional information gathered that would be relevant to comprehensive resident assessment using the MDS and RAPs)

NURSING NOTE

Resident incontinent of urine all three shifts since admission. His normal pattern at home was to toilet himself as needed, with additional reminders from his wife before leaving the house and at bedtime. Resident with a past history of enlarged prostate and urinary retention. Resident has daily bowel movements and passing moderate amounts of soft, formed stool. Digital exam is negative for feces in rectum. Mr. S is receiving tapering doses of Haldol. We expect the incontinence to resolve with diminishing Haldol doses, full treatment of UTI, and resolution of delirium. The decision was made to document bowel and bladder activity, I/O of fluids, assess for bladder distention, discuss with wife regarding past patterns for bathroom cueing, and to continue to review medications: Haldol, Bactrim DS.

K. Phillips, R.N.

2. DRAWING INFORMATION TOGETHER

This case example illustrates the types of activities and dialogue that occur as staff gathers information and structure care during the first few days of a resident's stay in the facility. Using this and other information, staff would complete the MDS. Each discipline would complete their assigned portion of the MDS, cross check the assessment across disciplines and shifts for accuracy, and then have it signed off by the RN.

3. FURTHER ASSESSMENT USING RAP GUIDELINES

The RAP review and assessment process provides a time for staff to think about and discuss key areas of concern related to the resident. There are many ways to structure this assessment process, e.g. who leads the discussion or assessment, who participates, and how the resident, family and physician are involved. But in each case, staff should:

Based on the case study presented above, staff should review the MDS to determine which RAPs should be triggered. Using delirium as an example, possible ways in which staff could proceed are indicated below.

- Discuss the triggered problems and any current treatment goals and related approaches to care.
- Identify the key causal factors (i.e., why the problem is present).
- Review the associated and confounding factors referenced in the RAP Guidelines (i.e., things that contribute to the problem or add to the complexity of the situation).
- Ensure that information regarding the resident's status and clinical decision-making is documented, and that the RAP Summary form identifies where this documentation can be found.
- Proceed to Care Planning.

1. The Delirium RAP was used throughout the initial assessment period. It was clear from admission that Mr. S had acute confusion. Predictably, the Delirium RAP was triggered. Staff documentation throughout the first weeks of residency captures the key elements of the Delirium RAP assessment. The location and date of this documentation is entered on the RAP Summary form. The decision to care plan is indicated. As key information is clearly documented in this example and readily accessible to all staff, there is no additional documentation required beyond the RAP Summary form and referenced notations and care plan.

2. In some cases, a staff person may want to write a summary of the RAP assessment. This could be for several reasons: e.g., while the assessment documentation is in the record it is incomplete, unclear, too scattered or not focused. It may also be useful to have the information summarized for quick reference by staff. If this is the case, the summary note for Delirium could look like this:

Delirium: RAP Summary Example 1

Mr. S admitted from hospital with diagnosis of acute confusion. Since admission his cognition has steadily cleared. Indicators of delirium, such as being easily distracted, having altered perception or

awareness of surroundings, and restlessness have lessened, but are not completely gone. Mr. S has a history of Alzheimer's disease, family have been very helpful in describing his baseline cognition. The team believes that delirium is related to his UTI, relocation, Haldol, Morphine, Zantac, and dehydration. Haldol is being tapered with the goal of elimination (he was not on this drug prior to hospitalization), Morphine and Zantac have been discontinued, UTI has been treated with Bactrim DS - a follow up U/A C+S will be sent upon completion, I/O is being monitored and fluids being encouraged, and the family has been helping us simulate a homelike environment with Mr. S's possessions and routine.

Another example could look like this:

Delirium: RAP Summary Example 2

Mr. S triggered for delirium. RAP was used as a guideline for assessment by team. (See nursing notes: 8/24/02, 8/28/02, MD note 8/25). Possible causal factors: UTI, Medication, Dehydration, Relocation have been identified and treatment plans are indicated. Refer to Delirium care plan.

4. CARE PLAN SPECIFICATION

The following is an example care plan for Delirium. It contains general points, rather than specific prescriptions. It is meant to show general culmination of the assessment process in the plan of care.

Objective	Intervention	Evaluation
Mr. S will remain safe and have no injuries in next 30 days	• Keep night light on in room at night. • Have family bring in familiar articles (bedspread, pictures). • 15-minute checks while in room, encourage out of room activities. Involve in low stimulus activities. • Keep pathways clear and free from clutter. • Toilet q 2 hours while awake and q 4 hours during night. Offer frequent snacks including beverages.	• Resident remained safe in last 30 days, with no evidence of injury.
Mr. S's cognitive function will return to baseline[3] in 30 days	• Taper Haldol as ordered. • Continue to review all medications with physician. • Assess for adequate hydration by monitoring daily fluid intake. • Review requested notes from Adult Day Care to gain further insight into baseline. • Continue with Tylenol for pain, give PRN dose before physical therapy and if resident appears agitated or withdrawn.	• Resident's cognitive functioning appears similar to baseline[3] according to: family, documentation from Adult Day Care and cognitive clinic at hospital. • Resident received Tylenol as ordered, and did not appear to be in pain.
Mr. S and family will be acclimated to the unit in 30 days as evidenced by recognizing his own room and participating in unit activities with minimal supervision	• Primary team to meet with family to work on care plans and tour unit. • Involve family in all aspects of care. • Assess family's level of knowledge about Alzheimer's disease and acute confusion. • Reorient Mr. S to his room and surrounding unit. As acute confusion begins to clear, involve Mr. S in more of unit activities.	• Family met with primary care team and toured the unit. Mr. S is able to recognize his room and attend unit activities with a staff prompt.
Resident will maintain adequate nutrition and hydration over next 30 days as evidenced by eating at least 3/4 of his meals and drinking 2 liters of fluid each day	• See urinary incontinence care plan. • Carefully assess fluid intake from meal trays. Offer supplemental fluids in between meals. Involve family in determining the best fluids; Mr. S likes chocolate milk and apple juice. • Review monitored intake and output sheets from last 7 days. • Monitor skin turgor and mucous membranes.	• Mr. S's intake was at least 2000. • Resident received supplemental beverages in between meal. • Skin turgor is intact and mucous membranes are moist.

[3]Assumes description of baseline is documented elsewhere in the clinical record.

4.11 Overview of the RAI and Care Planning

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This section provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review, which is carried out utilizing the Guidelines that have been developed for each RAP. Staff uses RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. After using the RAP Guidelines to assess the resident, the staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan. Conversely, the staff may decide that items that were not triggered do affect the resident's functioning or well-being and therefore should be addressed on the care plan.

The care planning process in long-term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident

by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well-being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision-making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.

2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.

3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.

4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Documentation may be done by

individual staff members who have completed assessments using the RAP Guidelines or who participated in care planning, or as a joint note by members of the interdisciplinary team.

5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.

6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of well-being. The resident's wishes should be documented in the clinical record.

7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

EXAMPLES

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.

9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.

10. The parts of the goal statement should include:

    The **Subject** - the **Verb** - **Modifiers** - the **Time frame**. See following example.

EXAMPLE

Subject	*Verb*	*Modifiers*	*Time frame*
Mr. Jones	will walk	up and down 5 stairs with the help of one nursing assistant	daily for the next 30 days.

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.

12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.

13. The final care plan should be discussed with the resident or the resident's representative.

14. The goals and their accompanying approaches are to be communicated to all direct care staff who were not directly involved in the development of the care plan.

15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

4.12 The Care Planning Process

The care planning process is based on good clinical practice and specified in the interpretive guideline probes for the care planning requirements at 42 CFR 483.20(k)(1) and (2). The appropriate **F Tags** have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in **Appendix P** of the State Operations Manual (SOM). The SOM can be found at the following web site: **http://www.cms.gov/manuals/pub%5F07.asp**.

The care plan must be oriented toward preventing avoidable declines in functioning or functional levels - F 279

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

Managing risk factors in the care plan - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

Addressing resident strengths in the care planning process - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

Utilizing current standards of practice in the care plan - F 281

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

Evaluating treatment objectives and outcomes of care in the care planning process - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline-in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

Respecting the resident's right to refuse treatment - F 279 and F280

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether or not they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how

a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

Offering alternative treatments - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff that has regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

Utilizing an interdisciplinary approach to care plan development to improve resident's functional abilities - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff is usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each member's contribution should be sought and valued.

Family and other resident representatives involvement in care planning - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality

of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this fact and that individual should be given the opportunity to participate in the assessment and care planning process.

Assessment and care planning sufficient for meeting the care needs of new admissions - F 281

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20(a) Tag F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident were incontinent of urine at the first admission, or newly incontinent at re-admission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

Involving the direct care staff with the care planning process relating to the resident's expected outcomes - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff has the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff

to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether or not specific program variations might be useful.

Additional care planning areas that could be considered in the long-term care setting - F 280

The following are six general care planning areas that are useful in the long-term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

1. **Functional Status**

   Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

2. **Rehabilitation/Restorative Nursing**

   A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative-nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

3. **Health Maintenance**

   Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

   The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

   Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

4. **Discharge Potential**

   Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before

the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

5. **Medications**

The facility must conduct initially and periodically a comprehensive assessment of a resident's needs including medications **(See 483.20(b)(1)(xiv))**. This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facility staff on a monthly basis.

It is the interdisciplinary team's decision whether or not medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications that may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

Many medications have been identified that are judged to place a person over the age of 65 at greater risk of adverse drug outcomes. These were identified in a paper published in the *Archives of Internal Medicine*, Vol. 157, July 28, 1997 entitled "Explicit Criteria for Determining Inappropriate Medication Use by the Elderly" by Mark H. Beers, M.D., and are outlined in the State Operations Manual, Appendix PP, Guidance to Surveyors, Tag F329, 42 CFR 483.25(1)(1). The interdisciplinary team will want to carefully review the use of any of these medications and care plan for possible side effects.

6. **Daily Care Needs**

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

Clarifications: ◆ For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. In most nursing facilities, the timing of such routines is fairly standardized. If that is not the case, then specific times should be noted. Good clinical practice dictates that any care plan be periodically evaluated

and revised as necessary, which would include documentation of the resident's response to the program.

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- The plan of care should present a true picture of the resident's status. It should therefore be revised with any major change of condition (decline or improvement), as well as completing a Significant Change in Status assessment. Refer to Chapter 2 for guidelines for Significant Change in Status assessment.